PROVIDER INSTRUCTIONS
RENEWAL REQUEST FOR MENTAL HEALTH SERVICES

Your client has reported that you have provided crime-related treatment and has provided this Program with an authorization to obtain and/or review any and all medical records concerning this treatment. The Program requires justification for payment of sessions beyond the initial 16 sessions originally approved.

Please complete the attached Renewal Request and return it directly to the CVC Program. You should be thorough in documenting the need for continuing treatment as it relates to the crime. PAYMENT WILL NOT BE CONSIDERED UNTIL THE COMPLETED FORM IS RECEIVED.

In providing compensation for mental health counseling, the CVC Program must ensure that the treatment is only as intensive and extends only as long as necessary to restore the victim to a level of functioning consistent with that immediately prior to the victimization. Consequently, the initial authorization allows payment for 16 sessions only. Justification for payment of additional sessions must be clearly defined in the form attached. Unfortunately, counseling dealing with family or relationship dysfunction, parenting skills, common adolescent problems or any other pre-existing or unrelated condition is not compensable.

The information you submit on this form will be reviewed by the Director of Crime Victim Compensation and the applicant will be informed whether payment for additional sessions will be approved.

If there are any other sources to pay for therapy expenses (such as insurance, Medical Assistance or Medicare, etc.), the bills **must** be submitted to that source first. **The Crime Victim Compensation Program will only consider payment of a bill after it has been processed by every other available source. If this Program determines that a claimant had a collateral source that would have covered the charges, but chose to receive treatment by a provider not covered by that source, the payment may be denied by this Program.** If the patient advises you that this Program will cover the charges, you should verify that information with this Program. If the victim/claimant is eligible for a sliding fee scale, the provider must bill the Program no more than the sliding fee scale.

The Program **cannot** cover**:**

missed appointments	sessions with the offender
court appearances	travel time
advocacy functions	interest on charges
report writing	case management
telephone counseling	criminal investigative procedures
reunification sessions	counseling for issue not directly related to the crime

YOU MUST BILL YOUR CLIENT. This is done because your client may be responsible for all or a portion of their bills. If you wish to expedite this claim, you may send duplicate copies of the itemized bills that are sent to the claimant, along with copies of the corresponding insurance explanation of benefit forms, to the address below:

Crime Victim Compensation Program
PO Box 7951
Madison, WI 53707-7951

If you have any questions please call 608-264-9497 and ask to speak with the Claims Specialist handling this claim. This form can be faxed to 608-264-6368.

Revised 5/09

RENEWAL REQUEST FOR MENTAL HEALTH SERVICES

Crime Victim Compensation Program
PO Box 7951
Madison, WI 53707-7951

CLAIM #: _____

MENTAL HEALTH THERAPY PROVIDER INFORMATION

Therapist Name & Title:

Telephone:

Federal Tax ID Number:

Agency Name & Address:

License Number:

SECTION I: VICTIM/SURVIVOR INFORMATION

Name:

D.O.B.:

Address:

Date Entered Treatment:

Frequency of Treatment Sessions:

Health Insurance Carrier:

Number of Sessions to Date:

List any new events in the victim/survivor's life since treatment began that are impeding treatment progress.

SECTION II: VICTIM/SURVIVOR TREATMENT ISSUES

Please summarize progress toward treatment goals since last report.

Please list any pre-existing mental health issues identified prior to the date of the crime. If your treatment focus includes conditions that occurred prior to the crime but are exacerbated by the crime, please describe those conditions, how they are exacerbated and how they will be addressed.

Please Note: The Victim Compensation Program can only pay for the percentage of treatment that is necessary as a direct result of the crime for which the application was filed. In your opinion, what percentage of your treatment is necessary as a direct result of the qualifying crime?

- ☐ 0%
- ☐ 25%
- ☐ 50%
- ☐ 75%
- ☐ 100%
- ☐ Other: _____ %

In the past 3 months, has this victim exhibited any of the following symptoms at a level that you consider clinically significant? Check all that apply:

Aggression	Dissociation	Obsessive Behavior
Anger	Emotional numbing	Panic
Anxiety	Fear	Phobias
Apathy	Flashbacks	Self-blame
Avoidance	Guilt	Self-destructive Relationships
Behavior Problems	Harm/Threats to Others	Self-harm Behavior
Compulsive Behavior	Hyperactivity	Sexual Acting Out
Crying	Hyperarousal	Sexual Dysfunction
Denial	Insomnia/Sleep Problems	Somatic Complaints
Depression	Irritability	Substance Abuse
Difficulty Concentrating	Memory Problems	Substance Abuse Withdrawal
Disordered Eating Symptoms	Nightmares	Other

Please state your goals for the additional treatment sessions and how you hope to accomplish these goals using objective and measurable goals.

Medications and dosages currently prescribed that have changed since the first report (please **circle** those directly related to crime):

Is the victim/survivor currently disabled from working due to the mental health condition **directly** related to the crime?
No ___ Yes ___ If yes, provide: the date disability began_____
and the date the victim/survivor will be able to return to work: _____

Based on the information presently available, please rate the victim's prognosis for resolution of the crime related concern for which you were consulted:

Excellent	Good	Fair	Poor

Frequency of therapeutic contacts: _____ Anticipated date of termination:_____

Circumstances that would extend or shorten the period until termination date:

SECTION III: OTHER PERTINENT INFORMATION

Please add additional information not in the assessment and treatment plan if necessary. If more space is needed, attach a separate document to this plan.

SECTION IV: SIGNATURE

The information contained herein is correct to the best of my knowledge, information and belief. I understand and agree to the following:

1. I meet the requirements as listed in Wisconsin Rule JUS 11.06;
2. Under the statutes and rules applicable to the Crime Victim Compensation Program as the payer of last resort, I agree to apply for any insurance benefits of the victim, including, but not limited to, Medicaid/Medicare, to which the victim may be entitled and I agree to apply the sliding fee scale that would be billed to the victim in billing the Crime Victim Compensation Program;
3. I will cooperate with the Program for requests for information needed to determine initial and continuing eligibility for the Program.

_____ _____
Therapist's Signature Date